SECTION 2

TARGETED CASE MANAGEMENT FOR THE CHRONICALLY MENTALLY ILL

Table of Contents

1 GENERAL POLICY

Targeted case management is a service that assists eligible clients in the target group to gain access to needed medical, social, educational, and other services. The overall goal of the service is not only to help Medicaid recipients to access needed services, but to ensure that services are coordinated among all agencies and providers involved.

1 - 1 Authority

The Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272, COBRA) added targeted case management to the list of optional services which can be provided under the State Medical Plan.

1 - 2 Definitions

Chronically mentally ill: means those individuals who meet criteria specified in the Utah Mental Health Program Evaluation Committee (UMHPEC) Scale on the Persistently and Seriously Mentally Ill. (See Appendix 1.)

CHEC: Child Health Evaluation and Care is Utah's version of the federally mandated Early Periodic screening Diagnosis and Treatment (EPSDT) program. All Medicaid eligible clients from *birth through age twenty* are enrolled in the CHEC program. The only exception to this policy is that Medicaid clients age 19 and older enrolled in the Non-Traditional Medicaid Plan are **not** eligible for the CHEC program. The Medicaid Identification Cards for individuals enrolled in the Non-Traditional Medicaid Plan are blue in color and specify that the individual is enrolled in this plan.

DHCF: Division of Health Care Financing

1 - 3 Target Group

A. Targeted case management services may be provided to the chronically mentally ill for whom the service is determined to be medically necessary. Targeted case management services will be considered medically necessary when a needs assessment, completed by a qualified targeted case manager, documents that:

   1. The individual requires treatment and/or services from a variety of agencies and providers to meet his or her documented medical, social, educational and other needs; and

   2. There is reasonable indication that the individual will access needed treatment/services only if assisted by a qualified targeted case manager who (in accordance with an individualized case management service plan) locates, coordinates and regularly monitors the services.

B. Currently, the Utah Medicaid program provides coverage of targeted and home and community based waiver services (HCBWS) case management for a variety of other target groups:

   1. CHEC (EPSDT) eligible children
   2. Substance abuse;
   3. Early Childhood Development
   4. Homeless individuals;
   5. Pregnant women;
   6. Individuals with a diagnosis of HIV/AIDS;
   7. Individuals with a diagnosis of tuberculosis;
   8. Individuals with Physical Disabilities (HCBWS waiver);
   9. Developmentally Disabled / Mentally Retarded (HCBWS waiver);
   10. Individuals Aged 65 and over (HCBWS Waiver)
   11. Technology-Dependent Children (HCBWS Waiver)
   12. Individuals with Traumatic Brain Injury (HCBWS Waiver)

There are separate rules and provider manuals to address the scope of services and reimbursement methods for the other target groups. Since a Medicaid child may qualify for targeted or waiver case management services under multiple groups, the case manager must determine if other agencies are already providing such services before providing service. Coordination of all services is an essential component of targeted case management.

1 - 4 Qualified Targeted Case Management Providers

Targeted case management for the chronically mentally ill must be provided only by employees of comprehensive community mental health centers. Qualified targeted case managers include:

A. licensed mental health professionals, including licensed physician, licensed psychologist, licensed clinical social worker, licensed certified social worker, licensed social service worker, licensed advanced practice registered nurse, licensed registered nurse, licensed professional counselor, licensed marriage and family counselor, who are employed by a comprehensive community mental health center; or

B. non-licensed individual working toward licensure as one of the above and under appropriate supervision.

C. licensed practical nurses or non-licensed individuals who have met the State Division of Mental Health's training standards for case managers, and who are supervised by one of the licensed mental health professionals identified above.

(See Title 58, Chapter 60, of the Utah Code Annotated, 1953, as amended, or the Mental Health Professional Practice Act for supervision requirements.)

1 - 5 Targeted Case Management Training Curriculum

To meet the State Division of Mental Health's training standards, all non-licensed individuals will be required to:

A. successfully pass a written examination which tests basic knowledge, attitudes, and case management skills; and

B. successfully complete a 20-hour case management practicum over a two-week time period.

In addition, all case managers must be familiar with Medicaid regulations pertaining to targeted case management.

1 - 6 Client Rights

A. Targeted case management services may not be used to restrict the client's access to other services available under the Medicaid State Plan.

B. The mental health center must have a process to ensure that the client (or the client's guardian if applicable) voluntarily chooses targeted case management services, and is given a choice in the selection of their targeted case manager.

2 SCOPE OF SERVICE

2 - 1 General Limitations

Effective July 1, 2002, certain Medicaid adult clients age 19 and over in the TANF and Medically Needy Medicaid eligibility categories have a reduced benefits package. These clients' Medicaid cards will be blue.

Medicaid clients with the reduced benefits package will have the following service limitations:

Outpatient mental health services/visits– There is a maximum of 30 outpatient mental health treatment services/visits per client per year for outpatient mental health care. Targeted case management services for the chronically mentally ill also count toward the 30 outpatient services/visits maximum. See Utah Medicaid Provider Manual for Mental Health Centers, Chapter 2 - 1, General Limitations, for additional service limitations.

2 - 2 Covered Services / Activities

A. Targeted case management is a service that assists eligible clients in the target group to gain access to needed medical, social, educational, and other services. The overall goal of the service is not only to help Medicaid recipients to access needed services, but to ensure that services are coordinated among all agencies and providers involved.

B. Medicaid reimbursement for targeted case management is dictated by the nature of the activity and the purpose for which the activity was performed. When billed in amounts that are reasonable (given the needs and condition of the particular client) the following activities/services are covered by Medicaid under targeted case management:

1. assessing and documenting the client's need for community resources and services;

2. developing a written individualized, coordinated case management service plan to assure the client's adequate access to needed medical, social, educational and other related services with input, as appropriate, from the client, family and other agencies knowledgeable about the client's needs;

3. linking the client with community resources and needed services, including assisting the client to establish and maintain eligibility for entitlements **other than Medicaid** (see Chapter 2 - 3, item H);

4. coordinating the delivery of services to the client, including CHEC screening and follow-up;

5. instructing the client or caretaker, as appropriate, in independently obtaining access to needed services for the client;

6. assessing, periodically, the client's status and modifying the targeted case management service plan as needed; and

7. Periodic monitoring of the client to ensure needed services have been identified and that they are being obtained in a timely manner;

8. Monitoring the quality and appropriateness of the client's services; and

9. Monitoring the client's progress and continued need for targeted case management and other services.

C. The agency may bill Medicaid for the above activities **only if**:

1. the activities are identified in the case management service plan; and

2. the time spent in the activity involves a face-to-face encounter, telephone or written communication with the client, family, caretaker, service provider, or other individual with a direct involvement in providing or assuring the client obtains the necessary services documented in the targeted case management service plan.

D. Covered services provided to patients in a hospital, nursing facility or other institution may be covered only during the 30-day period prior to the patient's discharge into the community, and is limited to five hours per inpatient stay. Only those centers that have requested and received authorization from the Division of Health Care Financing (DHCF) to bill for this specific service under a unique billing code may request reimbursement for targeted case management services provided to an institutionalized client.

2 - 3 Non-covered Services / Activities

In accordance with federal Medicaid guidelines, the following activities are not considered targeted case management and may not be billed to Medicaid:

A. documenting targeted case management services - with the exception of the time spent developing the written needs assessment, service plan, and 180-day service plan review - is not reimbursable as targeted case management.

B. teaching, tutoring, training, instructing, or educating the client or others, except in so far as the activity is specifically designed to assist the client, parent, or caretaker to independently obtain needed services for the client. For example, assisting the client to complete a homework assignment, or instructing a client or family member on nutrition, budgeting, cooking, parenting skills or other skills development is not reimbursable as targeted case management;

C. directly assisting with personal care or activities of daily living (bathing, hair or skin care, eating, etc.) or instrumental activities of daily living (assisting with budgeting, cooking, shopping, laundry, home repairs, apartment hunting, moving residences, or acting as a protective payee) are not reimbursable activities under targeted case management;

D. performing routine services including courier services. For example, running errands or picking up and delivering food stamps or entitlement checks are not reimbursable as targeted case management;

E. providing other Medicaid services. For example, providing medical and psycho-social evaluations, treatment, therapy and counseling that are otherwise billable to Medicaid under other categories of service, are not reimbursable as targeted case management;

F. traveling to the client's home or other location where a covered case management activity will occur is not reimbursable, nor is time spent transporting a client or a client's family members;

G. providing services for or on behalf of other family members that do not directly assist the client to access needed services. For example, counseling the client's sibling or helping the client's parent obtain a mental health service are not reimbursable as targeted case management;

H. performing activities necessary for the proper and efficient administration of the Medicaid State Plan, including assisting the client to establish and maintain Medicaid eligibility. For example, locating, completing and delivering documents to the Medicaid eligibility worker is not reimbursable as targeted case management; and

I. recruitment activities in which the center or case manager attempts to contact potential recipients of service are not reimbursable as targeted case management.

J. time spent assisting client to gather evidence for a Medicaid hearing or participating in a hearing as a witness is not reimbursable as targeted case management; and

K. time spent coordinating between team members for a client is a non-billable activity.

2 - 4 Limitations on Reimbursable Services

A. **Team Case Management**

Targeted case management services provided to a client by more than one case manager employed by the center are reimbursable only under the following conditions:

1. all members of the team meet the qualifications described in Chapter 1 - 4;

2. documentation of billed services is maintained in a single case file;

3. all services are delivered under a single case management service plan;

4. all team members coordinate with one another to ensure only necessary, appropriate and unduplicated services are delivered by all team members.

5. time spent by two or more members of the team in the same targeted case management activity may be billed only by one team case manager; and

6. the recipient is informed of and understands the roles of the team members.

*

B. **Mental Health Clinic Service**

Targeted case management services may be billed only if that service would not ordinarily be considered an integral part of the mental health clinical service. Services described in the mental health clinical manual as (1) a direct clinic service (i.e., evaluation, medication management) or (2) an indirect service (i.e., supervision of mental health staff, interdisciplinary team conference for the development of a clinical treatment plan) must not be billed as a case management activity. These services would be billed as clinic services or are included as an administrative cost in establishing the cost of mental health clinic services.

C. **See General Limitations in Chapter 2 - 1.**

3 RECORD KEEPING

3 - 1 Required Documentation

A. The case manager must develop and maintain sufficient written documentation for each unit of targeted case management services billed. Documentation must include at least the following:

Record: For each contact:

1. name of client;
2. date and actual time of service;
3. duration of the service;
4. units of service;
5. setting in which the service was rendered;
6. description of the case management activity as it relates to the service plan; and
7. signature of the individual providing the service;

B. Targeted case management services must be documented in 15-minute intervals.

C. The following documents must be contained in each client's case file:

1. A written individualized needs assessment which documents the client's need for targeted case management services;
2. a written, individualized targeted case management service plan that identifies the services (i.e., medical, social education, and other services) the client is to receive, who will provide them, and a general description of the targeted case management activities needed to help the client obtain or maintain these services; and
3. a written review of the service plan, every 180-days, summarizing the client’s progress toward targeted case management service plan objectives. The service plan review must be completed within the month due, or more frequently as required by the client’s condition.

4 SERVICE PAYMENT

4 - 1 Payment Methodology

A. Payment for targeted case management services is made on a fee-for-service basis.

B. Rates are based on a 15-minute unit of service.

C. Payment cannot be made for targeted case management services for which another payer is liable, nor for services for which no payment liability is incurred. Medicaid reimbursement is not available for services provided free of charge to non-Medicaid recipients.

5 REVISED PROCEDURE CODES FOR TARGETED CASE MANAGEMENT FOR THE CHRONICALLY MENTALLY ILL for services rendered on or after October 1, 2003

For each date of service, enter the appropriate five-digit procedure code as indicated below:

Codes	Service and Units	Limits per Patient
T1017	Targeted Case Management, per 15 min.	5 hrs. per patient, per inpatient admission

6 OLD PROCEDURE CODES FOR TARGETED CASE MANAGEMENT FOR THE CHRONICALLY MENTALLY ILL for services rendered before October 1, 2003

For each date of service, enter the appropriate five-digit procedure code as indicated below:

Codes	Service and Units	Limits per Patient	Prior Authorization
Y2085	Targeted Case Management, per 15 min.	No Limit	Not required
Y2090	Targeted Case Management, per 15 minutes, 30 days prior to discharge from a nursing facility or hospital	5 hrs. per patient, per inpatient admission	Required

Reserved for future use.

THE UTAH SCALE ON THE SERIOUSLY AND PERSISTENTLY MENTALLY ILL (SPMI)
(FOR USE WITH ADULTS, YOUTH, AND CHILDREN)

DIMENSION I -- SEVERITY: Must meet 3 or more (check all that apply):

( ) **A.** **MEDICATION**: Receives psychoactive medication as part of treatment.

( ) **B.** **DIAGNOSIS/PROBLEM**: Diagnosis between 296 and 316, Inclusively; or a problem of abuse victim syndrome

( ) **C.** **INAPPROPRIATE DEPENDENCY:** On others for any three of the following (1) food purchase and preparation (2) personal hygiene (3) transportation, (4) financial management (5) living arrangement, and (6) leisure management.

( ) **D.** **PRODUCTIVITY PROBLEM:** Is either (1) marginally employed and would be unable to be employed without mental health services, (2) employed in a sheltered setting, (3) unemployable, or (4) receives specialized school or other services (if under age 16).

( ) **E.** **SOCIAL ISOLATION:** Is socially isolated, without friends and social support systems. Uses mental health system for exchange, includes severe isolation in school (If under age 16).

( ) **F.** **PUBLIC ASSISTANCE:** Receives public assistance to meet basic needs. (Applies only to adult patients.)

( ) **G.** **SYMPTOM REMISSION**: Symptoms are in remission, but the patient's condition would seriously deteriorate without continued mental health treatment and support.

( ) **H.** **ANTI-SOCIAL BEHAVIOR:** Has pattern of serious anti-social, criminal or delinquent acts.

DIMENSION II -- PERSISTENCE: Must meet one of the following (please check):

( ) **I.** **MORE INTENSE TREATMENT:** History of a continuous episode of treatment more intensive than outpatient for two years or more.

( ) **J.** **OUTPATIENT TREATMENT:** History of a continuous episode of treatment in outpatient services for three years or more.

( ) **K.** **NO HISTORY:** Would meet **I** or **J** above if service history were available or has met the severity criteria for three years or more without service.

( ) **L.** **RESISTIVE TO TREATMENT:** Is resistive to treatment and would meet criterion **I** or **J** had the patient not terminated from service against advice. Includes mental-health-focused schooling (if under age 16).

( ) **M.** **PROSPECTIVE PERSISTENCE:** Extremely likely to meet criterion **I** or **J** by subsequent continuous service or is expected to meet the severity criteria for three years or more.

( ) Yes ( ) No Check yes if three criteria are met in Dimension 1 and at least one criterion is met in Dimension II (Yes = SPMI / No - Non SPMI).
(NOTE: Assessment must sufficiently document the items checked.)

MIS Note: Please make sure SPMI assessment is entered into computer.

____/____/____
Date Completed:

_____
Therapist's Signature

_____
Patient Name

ANCILLARY DEFINITIONS

Psychoactive Medication: For adults, this includes any of the major tranquilizers, MAO's, anti-depressants and related medications. Excluded would be minor tranquilizers. For children, any medication to control symptom would qualify.

Inappropriately Dependent: The patient is debilitated to the point that without active intervention by others, needs in a given area would not be met.

Marginally Employed: The patient is employed in a low level occupation which requires no special skills, training, or education and which pays minimum wage or below.

Public Assistance: This definition includes continuous, direct financial support in terms of grants, food stamps, etc., from public agencies and/or material or financial support by private or church charitable organizations.

In Remission: The symptoms of the original problem(s) are minimized due to a management regime.

More Intensive Than Outpatient: Any service more restrictive to the patient than outpatient services: state hospital, community inpatient, residential, and/or day treatment.

SUMMARY OF PROCEDURES

Who does the rating? Clinicians

Who is rated? Adult, youth and child patients; entire caseload; all new admissions/readmissions.

When is the rating made? After the first therapy session or first treatment planning meeting?

What is checked? Check every criterion that applies even if the minimum has already been met for classifying the patient as SPMI. The additional detail will be used in further refinement of the scale.

Frequency of update? Continuing patients ere rated at least annually, Centers may choose to update more frequently.

Where is the document stored? In the patient's chart.

When should ratings begin to be made on all current patients? As soon as Centers can organize to do so. Because Medicaid reimbursement for case management is an immediate benefit, some centers are planning to do the ratings in mid-February.

When should ratings begin to be made on new admissions and readmissions? Continuously, beginning the same day that the current patient ratings are begun, provided the patient meets the “When is rating done?” criterion above.

The SPMI scale was jointly developed by the Utah Mental Health Program Evaluation Committee (UMHPEC) which consists of representatives of Community Mental Health Centers and C-PEAR of the Division of Mental Health. Helpful suggestions were also received by the Utah Council of Mental Health Programs. For further Information on the scale, contact the Center for Program Evaluation and Research (C-PEAR) 1300 East Center Street, Provo, Utah 84606-0270 (801-373-4400, Ext.635).

INDEX